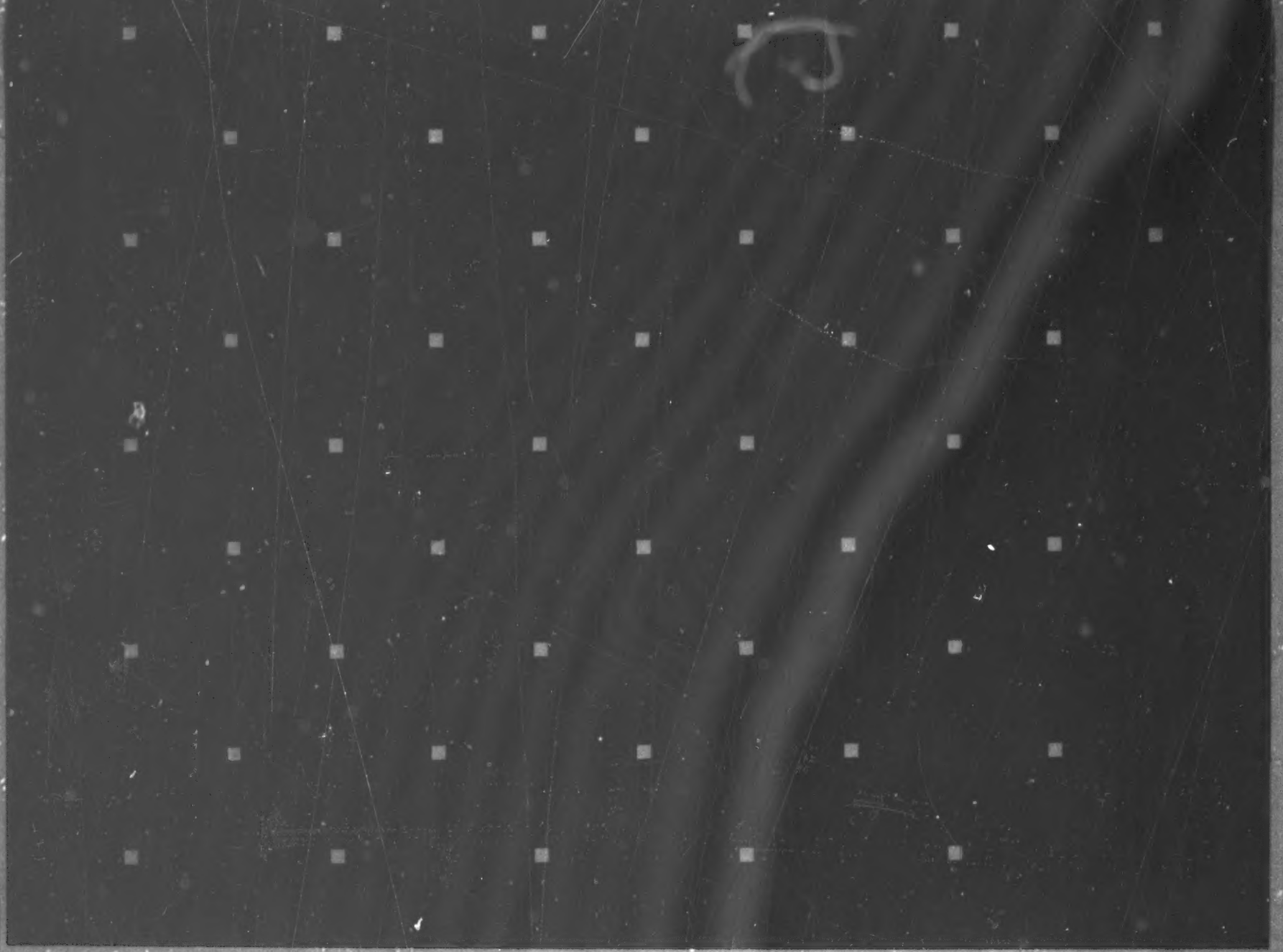

Table of Contents

Women and Alcohol Problems

TOOLS FOR PREVENTION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute on Alcohol Abuse and Alcoholism
5600 Fishers Lane, Rockville, Maryland 20857

Table of Contents

Women's Alcohol Problems	2
The Three Levels of Prevention–Primary, Secondary, and Tertiary	5
Primary Prevention–Five Tools for Stopping the Problem Before It Starts	6
Primary Tool One: Risk Factor Recognition	6
Primary Tool Two: The Media	8
Primary Tool Three: Legislation and Regulation	9
Primary Tool Four: Community Action Groups	9
Primary Tool Five: Health Education Programs	11
Secondary Prevention–Four Tools for Nipping the Problem in the Bud	12
Secondary Tool One: Alcohol Programs for Special Risk Groups	12
Secondary Tool Two: Employee Assistance Programs	13
Secondary Tool Three: Breaking the Silence of Denial	15
Secondary Tool Four: Assessment by Physicians and Other Helping Professionals	16
Tertiary Prevention–Four Tools for Treating Alcoholism	18
Tertiary Tool One: Denial Syndrome Recognition	18
Tertiary Tool Two: Direct Alcoholism Intervention	18
Tertiary Tool Three: Removal of Treatment Barriers	20
Tertiary Tool Four: Provision for Women's Special Treatment Needs	21
Summary	22
References	23

READEX

This brochure is a practical guide to the prevention of women's alcohol problems. It is intended for use by professionals, teachers, and community groups who want to incorporate prevention measures into the workplace, schools, treatment facilities, and other settings. *Women and Alcohol Problems: Tools for Prevention* also has utility for individual women and their families who want to reduce the risks of alcohol problems or prevent an existing problem from developing further.

prevention (pri-ven shən) n.Decisive counteraction to stop something from happening.

Sixty percent of all women in the United States drink alcohol at varying levels, according to the National Institute on Alcohol Abuse and Alcoholism (USDHHS 1983). Society places women (and men) who drink into the three basic categories of *social drinkers, problem drinkers,* and *alcoholics.* Before exploring alcohol problem prevention for women, it is necessary to dispel the myths behind these subjective categories.

■

SOCIAL DRINKERS

Social drinkers are those people who drink alcohol in small quantities for reasons of sociability (Bardsley and Beckman 1981). There is a problem inherent in defining "social drinker," however. How much is a small amount? The consumption level at which alcohol causes harmful effects varies between males and females, members of the same sex, and is even inconsistent for the same individual from day to day.

Although the amount of alcohol consumed by women who consider themselves social drinkers varies, for purposes of categorization here, it will be assumed not to exceed one or two drinks per day. This translates into a maximum of 3 ounces of 86 proof liquor, 10 ounces of 12 percent wine, or two cans of 4.5 percent beer.

The metabolism of alcohol is different in women and men because of differences in body makeup and hormonal influences. Since a woman's body has a lower percentage of water content than a man's body of equal weight, one alcoholic drink would result in a higher blood alcohol content (BAC) in her body and would thus have a more concentrated effect. Female hormones also play a role in the metabolism of alcohol. It appears that women are more

susceptible to the influence of alcohol just prior to menstruation, which means the female social drinker may need to adjust her consumption pattern accordingly (Litt 1981).

A common myth is that only heavy drinkers and alcoholics have alcohol-related problems. The truth is, however, that people who drink at lower levels cause and suffer from more than one-half of all adverse consequences of drinking (National Academy of Sciences 1981). This is because light and moderate drinkers occasionally experience episodes of intoxication that result in alcohol-related accidents, impaired job performance, and problems with interpersonal relationships.

Since many women who are actually problem drinkers mistakenly refer to themselves as social drinkers, it may be helpful to describe what a social drinker is not. Since a social drinker consumes alcoholic beverages in social situations, she is not a woman who often drinks alone. She does not drink to the point of drunkenness or to increase feelings of self-esteem. Her life is not complicated by negative situations brought about by her drinking, and her relationships are not adversely affected.

■

PROBLEM DRINKERS

Two women of equal height and weight may drink the same amounts, and one could be a social drinker while the other might be a problem drinker. The distinction? The problem drinker, unlike the social drinker, experiences adverse social, physical, or psychological consequences as a result of drinking alcohol. Some of these alcohol-specific problems include relationship problems with family or friends, job difficulties and absenteeism, and automobile or other accidents involving injury or property damage (West 1984). Difficulties in any or all of these areas could serve as signals that a woman has crossed the imaginary line from social to problem drinker.

There is evidence that a high tolerance for alcohol among some women may predispose them to problem drinking (USDHHS 1983). This means that since a woman with high tolerance may not feel the same alcohol-induced effects as a woman with lower tolerance, she may drink more to compensate. Since heavy drinking is usually problem drinking, a woman who discovers that her tolerance

for alcohol is high should be aware of her potential for problem drinking and should closely monitor her consumption.

The problem drinker is not necessarily an alcoholic. But if the problem drinker continues to consume alcohol at a level and over a period of time that, again, varies between individuals, she may become physically dependent on alcohol: she may become an alcoholic.

■

ALCOHOLICS

While the social drinker drinks for sociability, and the problem drinker often drinks for sociability, inadequacy, and escape reasons, the alcoholic may drink for all of these reasons, and for avoidance of withdrawal symptoms (Bardsley and Beckman 1981). Her disease has the general characteristics of addiction: craving, tolerance, and withdrawal phenomena. Alcohol tolerance is reflected in the need for markedly increased amounts of alcohol to reach the desired feeling or in the markedly diminished effects of the same amount of alcohol over a period of time. When an alcoholic woman stops drinking, she may experience "morning shakes," a sick feeling, or depression that her drinking used to relieve (USDHHS 1983). In cases of prolonged alcohol abuse, the withdrawal can be so traumatic that it can result in death—even in an otherwise healthy young adult (West 1984).

A special health danger for the female alcoholic is multidrug abuse, through the habitual misuse of tobacco, stimulants, sedatives, tranquilizers, or other drugs (USDHHS 1981). In a national membership survey of Alcoholics Anonymous, 40 percent of the female respondents reported addiction to an additional drug, as compared with 27 percent of their male counterparts (Alcoholics Anonymous 1984).

Chronic alcohol abuse affects almost all tissues in the body and can produce disease in nearly every organ (Wolf 1984). When an alcoholic woman abuses additional drugs, the substances can interact to speed up or compound the damage to her health.

■

The Three Levels of Prevention

Just as women's drinking patterns are often separated into the social drinker/problem drinker/alcoholic categories, prevention efforts are separated into the three categories, or levels, of *primary, secondary,* and *tertiary.*

At the first level, *primary prevention* efforts avoid the development of alcohol problems before they begin. The goal of primary prevention is to immunize individuals and the general community to stop any problem before it starts. The tools for primary prevention, which will be explored later in this brochure, are risk factor recognition, the media, legislation and regulation, community action groups, and health education programs.

Secondary prevention efforts attempt to identify alcohol consumers who run special risks of alcohol problems and help them minimize or eliminate the risks (USDHHS 1981). The goal of secondary prevention is to nip the problem in the bud before it becomes a chronic disease (Hill 1984).

Secondary prevention may be seen as early intervention. It includes any constructive action directed toward alcohol problems, or potential problems, that is not of a primary (general) nature and that is not direct treatment of alcoholism. Secondary prevention tools include alcohol programs for special risk groups, employee assistance programs, breaking the silence of denial, and assessment by physicians and other helping professionals.

The final level, *tertiary prevention,* is the actual treatment of alcohol abuse and alcoholism. The tertiary level is not prevention in the same sense as primary and secondary prevention. Rather, in tertiary prevention the target audience has already developed a problem with alcohol, so the object is to prevent further physical, social, and psychological damage. The tools of the tertiary level of prevention are denial syndrome recognition, direct alcoholism intervention, removal of treatment barriers, and provision for women's special treatment needs.

The next three sections describe the tools, or actions, associated with primary, secondary, and tertiary prevention, and how each may be utilized to prevent women's alcohol problems from developing or continuing.

Primary Prevention

Five Tools for Stopping the Problem Before It Starts

The goal of primary prevention is to reduce the incidence of alcohol problems in women. Since the primary level is prevention in the truest sense, it is the most difficult to measure in terms of success or failure.

PRIMARY TOOL ONE

RISK FACTOR RECOGNITION

There are currently no environmental influences, physiological or psychological traits that can predict with absolute certainty which women will develop alcohol problems. However, it is believed that both heredity and environment contribute significantly to the risk factor. *Risk factor recognition* is a valuable primary prevention tool because women who recognize their own personal risk factor can alter their lifestyles to reduce certain risks. With risk factors over which they have no control, they can closely monitor their alcohol intake or choose to remain abstinent.

Some of the factors that increase likelihood of alcohol problems for women are described below:

- *Heredity*–Daughters of alcoholic mothers may inherit a tendency toward alcoholism, but researchers have not been able to establish a similar link between daughters and alcoholic fathers (Bohman et al. 1981; USDHHS 1983; Niven 1984). Although the inherited tendency is still under study, the genetic risk for women appears to be mother-daughter limited (Niven 1984).

- *Age*–A woman's age plays a significant role in the risk assessment. Surveys have shown that drinking is most common among teenage girls and young women, and women are more likely to have alcohol-related problems in their thirties and forties (Beckman 1981; Wilsnack et al. 1982). Alcohol problems among elderly women, on the other hand, are relatively rare. Evidence exists that the percentage of drinkers begins to decline at age 50; however, from age 50 on, some older women who have been lifelong abstainers or moderate social drinkers become problem drinkers (Brody 1982; NASADAD 1981). Circumstances that may trigger alcohol abuse in these older women are retirement, loss of family and friends, isolation, loneliness, economic problems, and reduced mobility (NASADAD 1981).

- *Race*–Black and Hispanic women are more likely than white women to remain abstinent; however, the drinkers of these three races are equally susceptible to alcohol problems (Sandmaier 1980*b*). Native American women are at special risk for alcohol problems, and have the highest incidence of liver cirrhosis (USDHHS 1983).

- *Drinking Patterns of Others*–Women are strongly influenced by the drinking patterns of their husbands, siblings, and friends (Wilsnack et al. 1982). Heavy drinking by these significant others greatly increases a woman's risk factor for alcohol problems.

- *Unhealthy Lifestyles*–Women who abuse alcohol, tobacco, and prescription drugs and who have unhealthy lifestyles in general are at risk for developing alcoholism as well as other health problems (Ferrence 1984; Hill 1984).

- *Religion*–Women with no religious affiliation are more likely to have alcohol problems than women who identify themselves with a particular religion (Wilsnack et al. 1982).

- *Traumatic Experiences*–Many women with alcohol problems have reported that a painful life event—such as death of a significant other, divorce, or a serious illness—triggered their heavy drinking (Fine et al. 1980).

- *Homosexuality*–Lesbians are more likely than heterosexual women to develop alcohol problems, probably because of the gay bar's central role in the social lives of many lesbians (Sandmaier 1980*b*).

■

THE MEDIA

PRIMARY TOOL TWO

Various organizations–including the National Council on Alcoholism, the National Safety Council, the National Institute on Alcohol Abuse and Alcoholism, the National Highway Traffic Safety Administration, assorted private industries, and community groups–use television, radio, and print media as primary prevention tools. The campaign messages have been diverse–"Friends Don't Let Friends Drive Drunk," "When You Drink Don't Drive, When You Drive Don't Drink," "Before You Drink, Think," "Just Say No," "Drinking During Pregnancy Can Cause Birth Defects," etc.–but all share the common goal of preventing alcohol problems.

When planning prevention media campaigns, it is important to use the right kinds of media for target audiences. For example, teenage girls are best reached by radio, while women in their twenties and thirties are avid readers of the many magazines aimed at their age group (Sandmaier 1980*a*). Employed women frequently watch nightly TV news and late-night talk shows; and minority women can be effectively reached through the magazines and TV shows that are tailored for them (Sandmaier 1980*a*). Organizations such as

the National Clearinghouse for Alcohol Information can assist campaign planners by providing free information on medium selection, audience identification, message clarity, reliability, and other areas crucial to the success of prevention media campaigns.

Of course, planners must be aware that media campaigns, alone, will not prevent alcohol problems. Media messages should be used in conjunction with other community prevention efforts to maximize effectiveness.

■

PRIMARY TOOL THREE

LEGISLATION AND REGULATION

Legislative efforts can prove effective in reducing the incidence of certain alcohol-related problems, such as alcohol-impaired driving (USDHHS 1983). For instance, legislation to encourage all States to raise the minimum drinking age to 21 (PL98-363) was enacted by Congress in 1984. The passage of PL98-363 supported community efforts to prevent alcohol-related traffic fatalities among youth. Since young women in their teenage years appear to be drinking more, PL98-363 could prove highly beneficial for youth of both sexes.

Some communities have enacted legislation designed to discourage excessive drinking. Some of the more common regulations have typically included zoning restrictions to prevent taverns from operating near schools or churches or in residential areas; restrictions on operating hours; bans on extending credit to customers; and requirements that food be served with drinks (NAS 1981).

■

PRIMARY TOOL FOUR

COMMUNITY ACTION GROUPS

The community action group is a primary prevention tool that has become popular in the last decade. The groups are made up of individuals who share a concern for such specific alcohol-related problems as alcohol-related birth defects, alcohol-impaired driving, and drinking by minors. Community action groups often adopt acronyms such as MADD (Mothers Against Drunk Drivers), WRAP (Washington Regional Alcohol Program), CARS (Catch a Ride Safely), STIK (Stop the Teen Intoxication Kick), and SHOP (Students Helping Other People).

Voluntary associations, such as the YWCA and parents' groups, have acted as community action groups by implementing alcohol abuse prevention programs on the national, State, and local levels. In addition, some professional associations have endorsed and promoted prevention messages. Most notable among these have been the efforts of medical associations to alert women to the dangers of drinking during pregnancy, victim groups to prevent alcohol-impaired driving, and parent groups to encourage youth not to drink.

Private sector businesses are also becoming involved in community prevention activities, and outstanding contributions have been made by insurance companies, automobile dealers, soft drink manufacturers, sports teams, and privately owned print and broadcast outlets (USDHHS 1983).

The encouraging message conveyed by the efforts of all these groups is that responsibility for prevention is and must continue to be voluntarily shared. Community action groups can contribute greatly by generating enthusiasm, commitment, and awareness (USDHHS 1983).

■

PRIMARY TOOL FIVE

HEALTH EDUCATION PROGRAMS

In the workplace, health education programs, or "wellness programs," offer employees opportunities to modify their lifestyles in ways that promote good health. Assistance is typically offered in the areas of smoking, cardiovascular fitness, eating habits, and stress reduction. Not all wellness programs offer assistance in drinking-pattern modification, but increasing employees' awareness of health in general may cause some to reduce alcohol intake, and thereby avoid future problems (USDHHS 1983).

The need to target students 12 to 17 years old through school-based health education programs was underlined in a study done by Braucht (1982), who found that alcohol is the drug most often used by these students. Since this target audience is legally too young to drink, most school-based programs teach life skills (decision making, social interaction, etc.) and refusal skills (ways to say no to pressure from peers and other sources). Evaluation research indicates that such health education programs can result in an increase in knowledge, desirable changes in attitudes, and some changes in drinking patterns (Wittman 1982). Health education programs can also include health promotion efforts, especially those that spotlight desirable lifestyle changes.

■

Secondary Prevention

Four Tools for Nipping the Problem in the Bud

Until recently it was thought that alcohol problems could be addressed only by urging alcoholic individuals to enter treatment programs. Today, experts realize that alcoholism, like other diseases, cannot be eliminated simply by treating the casualties. More emphasis is being placed on early problem detection to prevent the disease from fully developing—the goal of secondary prevention, also known as *early intervention.*

ALCOHOL PROGRAMS FOR SPECIAL RISK GROUPS

SECONDARY TOOL ONE

Secondary and primary prevention are similar in that some of the same tools can be used for both prevention levels. For example, a school's alcohol education program is a primary prevention tool when it is directed at the entire student body. It would be a secondary prevention tool if directed at students with alcohol problems or those with a higher-than-average risk of developing problems, such as depressed women, daughters of alcoholics, and women who have been arrested for alcohol-impaired driving (USDHHS 1981).

One nationally known center that conducts a secondary prevention alcohol program targets its prevention efforts toward three groups of adult women at risk for alcohol problems: incest and battered victims, lesbians, and adult daughters of alcoholics (Ferrence 1984). Prevention activities at the Alcoholism Center for Women have included workshops for members of the three risk groups, intervention education for gatekeepers for women's groups, and training programs for helping professionals. Evaluative tests conducted by the Center showed that the target groups became more knowledgeable about alcohol and that those who had problems were more willing to seek treatment. Also, gatekeeper training resulted in increased instances of intervention and early treatment (Ferrence 1984).

■

SECONDARY TOOL TWO

EMPLOYEE ASSISTANCE PROGRAMS

Employee assistance programs (EAP) have been adopted by more than 5,000 major companies in the United States (West 1984). These workplace programs can function as a secondary prevention tool by offering employees and their dependents prevention counseling, referral, and treatment for problem drinking or alcoholism. The EAP may also provide assistance with many nonalcohol-related problems that could lead to the development of alcohol problems.

EAP's vary a great deal among companies, but most share seven components: 1. a written policy and procedures statement, 2. explicit labor-management cooperation in program development and operation, 3. designation of key organizational personnel to refer employees for appropriate diagnostic intervention, 4. orientation of supervisors and shop stewards about their responsibilities under the policy, 5. diffusion of information about the program to the entire work force, 6. health insurance coverage for the treatment of alcoholism, and 7. assurance of total confidentiality for those identified and referred through the program (USDHHS 1981).

Supervisors need to be sensitive to gender-related barriers to women's entry into EAP's. First, they should be aware that clues to problem drinking, such as deterioration in job performance, lateness, and absenteeism, are less pronounced in women than in their male counterparts (Harmon 1983). This means that supervisors must be sensitive to more subtle shifts in the job-related behaviors of female employees in order to identify instances when intervention is warranted. Second, both male and female supervisors find it much more difficult to confront women directly with drinking problems, so many women miss the opportunities afforded by EAP's (Reichman 1983).

■

SECONDARY TOOL THREE

BREAKING THE SILENCE OF DENIAL

Breaking the silence is a one-on-one tool for confronting a woman with problems related to her drinking. Any concerned person who comes into contact with a woman experiencing problems with her drinking may help break the silence that usually surrounds the subject of alcohol abuse. Such concerned persons could be coworkers, friends, relatives, employers, physicians, clergy, beauticians, school counselors, lawyers, or hospital staff (USDHHS 1981). The most obvious people to break the silence are, of course, family members because they are in positions to see the early formation of a drinking problem. However, family members sometimes add to the problem by helping the problem drinker hide her symptoms from outsiders. By covering up her illness, family members increase the likelihood that she will deny the problem to herself (Beckman and Amaro 1984).

In her book, *The Invisible Alcoholics: Women and Alcohol Abuse in America*, Sandmaier (1980*b*) offers the following advice to family members and friends who wish to help a problem drinker by breaking the silence:

"Probably the most effective time to discuss an alcohol problem with a woman you know is within a day or two of a situation in which her drinking was clearly a problem; a party where she got very drunk, a family dispute in which her drinking played a part, an alcohol-related accident. Choose a time when she is sober, both of you are in a fairly calm frame of mind, and there is an opportunity for a quiet, private conversation.

"Tell her straightforwardly and nonjudgmentally, that you are concerned about her drinking. Avoid the word alcoholism, which is not only threatening to most people but may not even be strictly accurate in her case. And take care not to adopt a lecturing, moralizing tone, for the slightest hint of condemnation in your voice or manner will be an instant turnoff. But at the same time, don't be put off by the excuses or denials which you will receive. Be prepared to back up your concern with concrete examples of ways in which her drinking has caused problems for herself and for others, including the most recent incident. And make clear that nearby help is available."

■

SECONDARY TOOL FOUR

ASSESSMENT BY PHYSICIANS AND OTHER HELPING PROFESSIONALS

Physicians, and often other helping professionals, are in key positions to alert female patients to problem drinking since women are more likely than men to use their services and to do so at an earlier stage of an illness (Ferrence 1984). As a regular practice, physicians should ask women questions about their drinking patterns and any negative social, legal, and/or physical consequences (Harmon 1983). If a patient becomes tense or evasive during this assessment, it may be taken as a signal for the physican to pursue the subject of alcohol problems further (Harmon 1983).

Materials to assist physicians in assessment of patients' drinking patterns have been developed by the National Institute on Alcohol Abuse and Alcoholism and are available through the National Clearinghouse for Alcohol Information.

For the patient whose drinking pattern includes negative aspects but no symptoms of addiction, the physician may suggest that she become abstinent. If she chooses, instead, to continue drinking, she may be encouraged to monitor her consumption closely. Often self-monitoring in itself will induce a spontaneous reduction in drinking (Braiker 1984). When practicing self-monitoring, the woman should record moods, feelings, thoughts, and situations that serve as drinking stimulus cues to increase her awareness of those times when she should not drink.

If a patient reports that she feels unable to control her drinking, or if she simply desires support for her efforts, the physician may refer her to self-help groups such as Alcoholics Anonymous or Women for Sobriety. The physician may also encourage the patient to contact local agencies that provide counselling and treatment for people with alcohol problems. ■

Tertiary Prevention
Four Tools for Treating Alcoholism

Tertiary prevention involves helping alcoholics stop drinking. Since alcoholism has no known cure, alcoholics must become lifetime abstainers, which may be a difficult process even with the assistance of the best treatment programs. Tertiary prevention, like treatment for any other disease, is more likely to succeed if it occurs in the early-to-middle stage of the disease–the earlier the better (USDHHS 1981).

The number of women in alcoholism treatment has steadily increased over the past 10 years. Some claim this increase shows a rising rate of alcoholism among women; but others assert, with more empirical support, that changing the social attitudes toward women with alcoholism has allowed more female alcoholics to "come out of the closet" and seek treatment (Braiker 1984).

DENIAL SYNDROME RECOGNITION

TERTIARY TOOL ONE

Like the female problem drinker, the female alcoholic is often prevented from facing her illness by those around her who try to "help." The husband and children who make excuses for her, the boss who continues to forgive her lateness, the doctor who writes a tranquilizer prescription to calm her nervousness, the policeman who escorts her home rather than arresting her, and the judge who does not convict her of an alcohol-related offense are all denying her disease and are literally killing her with kindness (Argeriou and Paulino 1976; Harmon 1983).

Many who come into contact with alcoholic women join in the denial syndrome. Resisting this tendency can be a powerful tertiary tool of earlier treatment and higher recovery rates for women.

DIRECT ALCOHOLISM INTERVENTION

TERTIARY TOOL TWO

Convincing the alcoholic she needs professional help is perhaps the most challenging aspect of tertiary prevention. For many years experts believed the alcoholic had to "hit bottom" before accepting help. Unfortunately, bottom usually was not reached until her physical, mental, and social potentials were so damaged by the disease they could never be fully restored (Wegscheider 1981).

But helping professionals now know that bottom for many alcoholic women may come long before their lives

are devastated. For instance, hitting bottom might occur when a woman is arrested for her first DWI offense, when she is embarrassed by her drinking behavior in a social situation, or when she is placed on probation for alcohol-related absenteeism. Traumatic occurrences such as these often prompt alcoholic women to seek early treatment for their disease.

Family members and/or friends can encourage an alcoholic woman to seek treatment through a process known as *direct alcoholism intervention.* Similar to the secondary tool of breaking the silence, direct alcoholism intervention is one of the most successful ways to motivate an alcoholic to seek treatment. Direct alcoholism intervention differs from breaking the silence in that it 1. involves many people who have been affected by the alcoholic's disease, 2. is scripted and orchestrated by a trained alcohol counselor, and 3. has professional treatment for the alcoholic as its goal (Wegscheider 1981).

The direct alcoholism intervention process begins when a concerned person contacts an alcohol counselor and discusses the alcoholic's situation. The counselor arranges a meeting of those who have the most influence in the alcoholic's life to explain direct alcoholism intervention. During this initial meeting the counselor stresses that the alcoholic is unable to stop drinking or to seek help for herself. The counselor may arrange one or many meetings of the group, depending on the particular situation. Each individual is asked to prepare a written list of specific, detailed instances when the alcoholic's behavior caused pain, danger, or embarrassment. The lists should be factual, like a newspaper story, rather than accusing or hostile, so the alcoholic will not become defensive.

On the day planned for direct alcoholism intervention, the entire group meets with the alcoholic and the counselor, usually in the counselor's office. Each person takes a turn, calmly reading his or her list to the alcoholic. Hearing episode after episode is usually defense-shattering for the alcoholic, and at the end of this planned crisis, the alcohol counselor presents the treatment plan that the group has agreed upon.

If the direct alcoholism intervention has been well planned, chances for successfully convincing the alcoholic to begin treatment are approximately 80 percent (Wegscheider 1981).

It should be emphasized that direct alcoholism intervention, as it is described here, should not be attempted except under the guidance of a professional alcohol counselor. While the technique has great potential for success, if done improperly it can become accusatory and result in even more guilt and denial.

■

REMOVAL OF TREATMENT BARRIERS

TERTIARY TOOL THREE

Women alcoholics face certain treatment barriers that cause them to underuse treatment services (Beckman and Amaro 1984). Some of these barriers are listed below:

- *Lack of Emotional Support*–Alcoholic women are more likely than their male counterparts to receive opposition to treatment from their family, friends, and even their physicians (Beckman and Amaro 1984).
- *Financial Concerns*–Most women who enter alcoholism treatment programs are in serious financial difficulty (Sandmaier 1980*b*). The lower financial resources of women, as compared with men, severely limit their treatment options.
- *Attitudes of Treatment Providers*–A longstanding myth concerning alcoholic women is that they are more difficult to treat and have a poorer prognosis than male alcoholics (Sandmaier 1980*b*). To challenge this myth, Vannicelli (1984) conducted a comprehensive review of the literature from a 9-year period. Of 259 studies, 23 were found with sex-specific outcome data. Of the 23, 18 showed no significant sex differences in treatment outcome, 4 showed superior outcome for women, and 1 showed superior outcome for men. Since negative outcome expectations can influence both therapists and female patients, Vannicelli has suggested that positive expectations by treatment providers could result in women doing considerably better than men in treatment.

■

TERTIARY TOOL FOUR

PROVISION FOR WOMEN'S SPECIAL TREATMENT NEEDS

While alcoholic women do not always require different or even separate treatment approaches from men, they may need additional treatment services (USDHHS 1981; Vannicelli 1984). Alcoholic women report that they are more likely to enter treatment programs that provide child care and counseling, support groups, therapy for battered women and incest victims, treatment for prescription drug addiction, job counseling, and medical and nutritional counseling for pregnant women (Beckman and Amaro 1984). They often cite the lack of such services as a reason for dropping out of treatment (Sandmaier 1980*b*).

■

Summary

The thirteen prevention tools described in this brochure–risk factor recognition, the media, legislation and regulation, community action groups, health education programs, alcohol programs for special risk groups, employee assistance programs, breaking the silence of denial, assessment by physicians and other helping professionals, denial syndrome recognition, direct alcoholism intervention, removal of treatment barriers, and provision for women's special treatment needs–have demonstrated potential for alcohol problem prevention. One other important tool, removal of the misplaced stigma associated with alcoholic women, has not been listed with the others. It is evolving slowly, as ignorance is replaced with understanding.

A woman with cancer or heart disease consults her physician at the first sign of a health threat, and her family and friends rally to provide emotional support. Although alcoholism has been recognized as a disease by the medical profession since 1956, the alcoholic is still viewed by many as weak or immoral, making alcoholism the "loneliest disease." Women use the denial of their alcohol problems, even to themselves, as a defense mechanism against the alcoholic stigma. The biggest step forward for prevention will come when the woman who first suspects a drinking problem feels as free to seek help as the one who discovers a lump in her breast.

■

References

Alcoholics Anonymous. AA surveys its membership: A demographic report. In: *About AA: A Newsletter for Professional Men and Women.* New York: General Service Office, 1984.

Argeriou, M., and Paulino, D. Women arrested for drunken driving in Boston: Social characteristics and circumstances of arrest. *Journal of Studies on Alcohol,* 37(5):648-658, 1976.

Bardsley, P.E., and Beckman, L.J. Perceived determinants and consequences of alcohol consumption among young women heavy drinkers. *International Journal of the Addictions* 16(1):75-88, 1981.

Beckman, L.J. The psychosocial characteristics of alcoholic women. In: Cohen, S. ed., *Drug Abuse and Alcoholism.* New York: Haworth Press, 1981. pp. 19-29.

Beckman, L.J., and Amaro, H. Patterns of women's use of alcohol treatment agencies. In: Wilsnack, S.C., and Beckman, L.J., eds. *Alcohol Problems in Women: Antecedents, Consequences, Intervention.* New York: Guilford Press, 1984. pp. 319-348.

Bohman, M.; Sigvardsson, D.; and Cloninger, C.R. Maternal incidence of alcohol abuse. *Archives of General Psychiatry,* 38(9):965-969, 1981.

Braiker, Harriet B. Therapeutic issues in the treatment of alcoholic women. In: Wilsnack, S.C., and Beckman, L.J., eds. *Alcohol Problems in Women: Antecedents, Consequences, Intervention.* New York: Guilford Press, 1984. pp. 349-368.

Braucht, G.N. Problem drinking among adolescents: A review and analysis of psychosocial research. In: National Institute on Alcohol Abuse and Alcoholism. *Special Population Issues.* Alcohol Health Monograph No. 4. DHHS Pub. No. (ADM) 82-1193. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1982. pp. 143-164.

Brody, J.A. Aging and alcohol abuse. *Journal of the American Geriatrics Society* 30(2):123-126, 1982.

Ferrence, R.G. Prevention of alcohol problems in women. In: Wilsnack, S.C., and Beckman, L.J., eds. *Alcohol Problems in Women: Antecedents, Consequences, Intervention.* New York: Guilford Press, 1984. pp. 413-442.

References

Fine, E.W.; Richman, S.A.; and Teichman, M.; Psychosocial differences between male and female alcoholics. In: Galanter, M., ed. *Currents in Alcoholism*, Vol. 7. New York: Grune & Stratton, 1980.

Harmon, M. Out of the closet. *MD* 4:142-148, 1983.

Hill, S.Y. Vulnerability to the biomedical consequences of alcoholism and alcohol-related problems among women. In: Wilsnack, S.C., and Beckman, L.J., eds. *Alcohol Problems in Women: Antecedents, Consequences, Intervention.* New York: Guilford Press, 1984. pp. 121-154.

Litt, Z.F. Substance abuse among adolescent females. *Focus on Women: Journal of Addictions and Health* 2(2):61-67, 1981.

National Association of State Alcohol and Drug Abuse Directors. Alcohol and drug abuse among the elderly: Out of sight, out of mind? *NASADAD Alcohol and Drug Abuse Report.* Washington, DC: NASADAD, 1981.

National Academy of Sciences. *Alcohol and Public Policy: Beyond the Shadow of Prohibition.* Washington, DC: National Academy Press, 1981.

Niven, R.G. Alcohol and the family. In: West, L.J., ed. *Alcoholism and Related Problems.* Englewood Cliffs, NJ: Prentice-Hall, 1984. pp. 91-109.

Reichman, W. Affecting attitudes and assumptions about women and alcohol problems. *Alcohol Health and Research World* 7(3):6-10, 1983.

Sandmaier, M. "Myths and Messages: Using the Media as a Prevention Tool." Paper presented at the Woman Next Door Symposium, Philadelphia, February 1980a.

Sandmaier, M. *The Invisible Alcoholics: Women and Alcohol Abuse in America.* New York: McGraw-Hill, 1980b.

U.S. Department of Health and Human Services. *Fifth Special Report to the U.S. Congress on Alcohol and Health.* DHHS Pub. No. (ADM) 84-1291. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1983.

U.S. Department of Health and Human Services. *Fourth Special Report to the U.S. Congress on Alcohol and Health.* DHHS Pub. No. (ADM) 82-1080. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1981.

References

Vannicelli, M. Treatment outcome of alcoholic women: The state of the art in relation to sex bias and expectancy effect. In: Wilsnack, S.C., and Beckman, L.J., eds. *Alcohol Problems in Women: Antecedents, Consequences, Intervention.* New York: Guilford Press, 1984. pp. 369-416.

Wegscheider, S. *Another Chance: Hope and Health for the Alcoholic Family.* Palo Alto, CA: Science and Behavior Books, 1981.

West, L.J. *Alcoholism and Related Problems.* Englewood Cliffs, NJ: Prentice-Hall, 1984.

Wilsnack, R.W.; Wilsnack, S.C.; and Klassen, A.D. "Women's Drinking and Drinking Problems: Patterns from a 1981 National Survey." Paper presented at the Annual Meeting of the Society for the Study of Social Problems, San Francisco, September 1982.

Wittman, F.D. Current status of research demonstration programs in the primary prevention of alcohol problems. In: National Institute on Alcohol Abuse and Alcoholism. *Prevention, Intervention, and Treatment: Concerns and Models.* Alcohol and Health Monograph No. 3. DHHS Pub. No. (ADM) 82-1192. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1982. pp. 3-57.

Wolf, S.G. The wages of excessive drinking. In: West, L.J., ed. *Alcoholism and Related Problems.* Englewood Cliffs, NJ: Prentice-Hall, 1984. pp. 27-55.

■

Important Prevention Messages for Women

Some women may not read literature on the subject of alcohol because they believe that such materials are just for alcoholics. To reach these women, NIAAA recommends that program planners incorporate alcohol prevention messages into a wide range of health and safety materials dealing with exercise, interpersonal communication, pregnancy, weight control, community services, career advancement, insurance benefits, and parenting.

Some of the important alcohol prevention messages that all women need to be aware of are listed below:

1. Generally, when a woman and a man drink equal amounts of alcohol, the woman experiences the effects more intensely. This is, in part, because a woman has a different fat-to-water ratio in her body. She may also notice that the effects of alcohol are intensified before her menstrual cycle.

2. Alcohol adds lots of calories, but it has no nutritional value. The average alcoholic beverage (beer, wine, or distilled spirit) contains about 150 calories, roughly the same caloric content as 2 waffles, 7 teaspoons of syrup, or 3/4 cup of whipped topping. A weight-conscious woman may want to adjust her alcohol intake to help her reduce or maintain her present weight.

3. Although some studies have indicated that small amounts of alcohol may prevent heart problems by raising high density lipoprotein (HDL) cholesterol levels, the same benefits may be derived from exercise. Exercise raises HDL cholesterol without adding empty calories and creating a risk of alcohol dependence.

4. The safest choice for pregnant women is not to drink. Remaining abstinent during pregnancy removes the risk of producing a child with alcohol-related birth defects. Fetal Alcohol Syndrome (FAS) and alcohol-related birth defects are irreversible, but completely preventable. Abstinent pregnant women also reduce the risk of spontaneous abortions.

5. Women who have recently experienced a traumatic event (separation, divorce, death of a significant other, children leaving home, retirement, etc.), or those who are in high-stress occupations, should be particularly cautious about the amounts of alcohol they consume. They should also be encouraged to seek safer and healthier ways to deal with problems and stress.

6. Daughters of alcoholics, lesbians, victims of incest or rape, and others who have been shown to run a higher-than-average risk of developing alcohol problems, need to learn about alcohol and its effects. Prevention programs should especially educate these women, and should provide as much information as possible about alcohol and its associated risks.

■

U.S. GOVERNMENT PRINTING OFFICE : 1985 O - 480-684

Prepared by the NIAAA
National Clearinghouse for
Alcohol Information
Box 2345
Rockville, Maryland 20852
(301) 468-2600